5160:1-1-01 **Medicaid: definitions.**

(A) This rule contains definitions generally used in determining eligibility for medical assistance.

(B) Definitions.

(1) "Abuse" means any action by an individual or entity that results in unnecessary costs to the medical assistance program.

(2) "Administrative agency" means the Ohio department of medicaid (ODM) and/or an agent of ODM authorized to determine eligibility for a medical assistance program.

(3) "Alien emergency medical assistance" (AEMA) as established in rule 5160:1-5-06 of the Administrative Code, means treatment of an emergency medical condition for certain individuals who do not meet the citizenship or satisfactory immigration status requirements.

(4) "Assets" means all income and resources of the individual and of the individual's spouse. This includes any income or resources the individual or the individual's spouse is entitled to, but does not receive, because of an action taken to avoid receipt of the asset by:

(a) The individual or the individual's spouse; or

(b) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; or

(c) Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(5) "Assignment" means an individual eligible for medical assistance has transferred his or her right, or the rights of any other individual for whom he or she can legally make an assignment, to collect and retain third-party and/or medical support payments to ODM up to the amount of medical services paid under the medicaid program.

(6) "Authorized representative" means a person, who is at least eighteen years old, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. If an individual has designated an authorized representative, all references to "individual" in regard to an individual's responsibilities include the individual's authorized representative.

(7) "Base eligibility" means the category of medical assistance for which an

individual meets the eligibility requirements described in Chapters 5160:1-3, 5160:1-4, and 5160:1-5 of the Administrative Code. Long-term care (LTC) services may be explored as a companion benefit to base eligibility. Special income level (SIL) eligibility, as described in paragraph (B)(74) of this rule, may be explored for an individual in need of LTC services who is over the income limit for base eligibility. If approved using SIL budgeting, the SIL eligibility becomes the individual's base eligibility category.

(8) "Caretaker relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes), and who is one of the following:

(a) The child's father, mother, brother, sister, stepfather, stepmother, stepbrother, or stepsister.

(b) The child's grandfather, grandmother, uncle, aunt, nephew, or niece, including such relatives with the prefix great, great-great, grand, or great-grand.

(c) The child's first cousin or first cousin once removed.

(d) The spouse of such parent or relative, even after the marriage is terminated by death or divorce.

(9) "Case record" means electronic or paper documents and information used to determine or redetermine an individual's eligibility for medical assistance.

(10) "Community spouse" means an individual who is not receiving long-term care (LTC) services and has a spouse who is receiving LTC services.

(11) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (as in effect August 1, 2016).

(a) This includes:

(i) A group health plan.

(ii) Health insurance coverage.

(iii) Medicare part A, as set forth in 42 U.S.C. 1395c to 1395i-5. (as in effect August 1, 2016) or part B, as set forth in 42 U.S.C. 1395j to 1395w-4 (as in effect August 1, 2016).

(iv) Coverage under medicaid, as set forth in Title XIX of the Social Security Act, other than coverage consisting solely of benefits

under the pediatric vaccine program set forth in 42 U.S.C. 1396s (as in effect August 1, 2016).

(v) Armed forces health insurance as set forth in 10 U.S.C. 1071 to 1110b (as in effect August 1, 2016).

(vi) A medical care program of the Indian health service or of a tribal organization.

(vii) A state health benefits risk pool.

(viii) A federal employee health plan offered under 5 U.S.C. 8901 to 8992 (as in effect August 1, 2016).

(ix) A public health plan.

(x) A peace corps volunteer health benefit plan under section 22 U.S.C. 2504 (as in effect August 1, 2016).

(b) Creditable insurance does not include:

(i) Coverage only for accident, or disability income insurance.

(ii) Liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance.

(iii) Workers' compensation or similar insurance.

(iv) Automobile medical payment insurance.

(v) Credit-only insurance.

(vi) Coverage for on-site medical clinics.

(vii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

(viii) Limited-scope dental or vision benefits.

(ix) Benefits for long-term care, nursing home care, home health care, or community-based care.

(x) Coverage only for a specified disease or illness.

(xi) Hospital indemnity or other fixed indemnity insurance, if purchased separately.

(xii) Medicare supplemental health insurance as defined under 42 U.S.C. 1395ss (as in effect August 1, 2016), coverage supplemental to the coverage provided to military or former military personnel under 10 U.S.C. 1071 to 1110b (as in effect August 1, 2016), and similar supplemental coverage provided to coverage under a group health plan.

(12) "Denial" or "deny" means a determination by the administrative agency that an individual is not eligible for one or more categories of assistance applied for by the individual.

(13) "Dependent child" means a person younger than age eighteen living with a parent or caretaker relative.

(14) "Early and periodic screening, diagnostic and treatment" (EPSDT) means screening, vision, dental and hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in 42 U.S.C. 1396d (as in effect August 1, 2016) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. Healthchek is Ohio's EPSDT program.

(15) "Electronic equivalent" means an electronic version of an Ohio department of job family services (ODJFS) or ODM form or application which has not been modified in any way other than format prior to completion and submission of that form to the administrative agency. The administrative agency is not required to accept forms that are altered.

(16) "Electronic protected health information" (ePHI) means any protected health information (PHI) that is maintained or transmitted in electronic form, regardless of the format.

(17) "Electronic signature" has the same meaning as in section 1306.01 of the Revised Code.

(18) "Erroneous payment" means a medicaid reimbursement made for an individual who was ineligible at the time services were received, regardless of the presence of fraud or abuse.

(19) "Family size" means the number of persons counted as members of an individual's medicaid household.

(20) "Federal adoption assistance" (AA) means the Title IV-E subsidy program as defined by the Adoption Assistance and Child Welfare Act of 1980.

(21) "Federal benefit rate" (FBR) means the supplemental security income (SSI)

current payment standard published annually by the social security administration.

(22) "Federal means-tested public benefit" means a benefit in which eligibility for the benefit or the amount of the benefit, or both, is determined on the basis of income or resources of the individual seeking the benefit. Medicaid, cash assistance, and food assistance are federal means-tested public benefits, but certain other benefits listed in 8 U.S.C. 1613(c) (as in effect August 1, 2016) are not considered means-tested.

(23) "Federal poverty level" (FPL) means a measure of income level determined annually by the office of management and budget as required by 42 U.S.C. 9902(2) (as in effect August 1, 2016).

(24) "Foster care maintenance" (FCM) means Ohio's Title IV-E foster care maintenance program, as described in rule 5101:2-47-01 of the Administrative Code.

(25) "Good cause" means circumstances that reasonably prevent an individual from cooperating with the administrative agency in the eligibility determination process. Factors relevant to good cause include, but are not limited to, natural disasters, riots or civil unrest, death or serious illness of the individual or a member of his/her immediate family, or the physical, mental, educational, or linguistic limitations of the individual.

(26) "Home and community-based services" (HCB services or HCBS) means services furnished under the provision of 42 C.F.R. 441, subpart G (as in effect August 1, 2016), that provide specific individuals an alternative to placement in a hospital, a nursing facility (NF), or an intermediate care facility for individuals with intellectual disabilities (ICF-IID) .

(a) Individuals found eligible for HCBS under a base eligibility category as defined in paragraph (B)(7) of this rule, are not considered institutionalized and are not subject to post eligibility treatment of income (PETI) as defined in paragraph (B)(56) of this rule.

(b) Individuals found eligible for HCBS using special income level (SIL) budgeting as defined in paragraph (B)(74) of this rule, are considered institutionalized and are subject to PETI.

(27) "Home and community-based (HCB) services waiver agency" means ODM or its designee that performs administrative functions related to an HCB services waiver program in accordance with agency 5160 of the Administrative Code.

(28) "Immigrant" means a person who comes to the United States with plans to live here permanently. This term includes refugees, asylees, parolees, and other entrants regardless of whether residing in the United States legally.

(29) "Income" means any benefit in cash or in-kind, received by an individual during a calendar month.

(30) "Income and eligibility verification system" (IEVS) means the electronic system that shares income and asset information among the social security administration (SSA), internal revenue service (IRS), state wage information collection agency (SWICA), agencies administering the state unemployment compensation (UC) laws, and the administrative agency.

(31) "Individual" means a person applying for or receiving medical assistance.

(32) "Individually identifiable health information" means information that is a subset of health information that includes demographic information collected from an individual and:

(a) Is created or received by a health care provider, health plan, employer or health care clearinghouse; and

(b) Relates to the past, present, or future physical condition or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual and either:

(i) Identifies the individual; or

(ii) There is a reasonable basis to believe the information can be used to identify the individual.

(33) "Initial processing" means taking applications for medical assistance, assisting applicants in completing the application, providing information and referrals, obtaining required documentation needed to complete processing of the application, and assuring completeness of the information contained on the application. Initial processing does not include evaluating the information on the application and supporting documentation, or making a determination of eligibility.

(34) "In-kind" means any benefit received other than cash.

(35) "Institution for mental diseases" (IMD) means a hospital, nursing facility, or other institution of more than sixteen beds which primarily provides diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

(a) A facility is an IMD, whether or not it is licensed as such, if it is operated primarily for the care and treatment of individuals with mental diseases.

(b) An institution for persons with cognitive impairments or other developmental disabilities is not an IMD.

(36) "Institutionalized" describes an individual who receives, or is likely to receive, for at least thirty consecutive days, long-term care (LTC) services in a medical institution or a long-term care facility (LTCF), home and community-based services (HCBS) using special income level (SIL) budgeting as defined in paragraph (B)(74) of this rule, or services under the program of all-inclusive care for the elderly (PACE) using SIL budgeting. Individuals found eligible for HCBS or PACE under a base eligibility category as defined in paragraph (B)(7) of this rule, are not considered institutionalized.

(37) "Institutionalized spouse" means an individual who is institutionalized as defined in paragraph (B)(36) of this rule, and is married to an individual who is not in receipt of LTC services.

(38) "Legal custodian" means a person who has legal custody, as defined in section 2151.011 of the Revised Code, and the right to have physical care and control of a minor child.

(39) "Legal guardian" means any guardian, as defined in section 2111.01 of the Revised Code, appointed by the probate court to have the care and management of a minor child.

(40) "Limited English proficiency" (LEP) means the inability of any person or group of persons to speak, read, write or understand the English language at a level that allows them to meaningfully communicate with the administrative agency.

(41) "Long-term care facility" (LTCF) means a medicaid-certified institution that provides medical care, including nursing and convalescent care, such as a nursing facility, skilled nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

(42) "Long-term care services" are medicaid-funded, institutional or community-based, medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services that may be provided to individuals eligible for medical assistance.

(43) "Medicaid buy-in for workers with disabilities" (MBIWD) as set forth in rule 5160:1-5-03 of the Administrative Code, is a category of medical assistance that enables workers with disabilities to earn income and have resources without the risk of losing health care coverage.

(44) "Medicaid eligibility fraud" means that an individual knowingly:

(a) Made or caused to be made a false or misleading statement; or

(b) Concealed an interest in property or failed to disclose certain transfers of property.

(45) "Medicaid household" means a group of individuals, defined in relationship to one specific medical assistance applicant or recipient, who impact the applicant or recipient's family size or household income.

(46) "Medical assistance" includes all programs administered by the state medicaid administrative agency.

(47) "Medical support" means an order by a court to provide medical coverage.

(48) "Medical verification of pregnancy" means a written statement signed by a licensed medical professional verifying pregnancy and includes the expected date of delivery and, if more than one, the expected number of fetuses.

(49) "Modified adjusted gross income" (MAGI or MAGI-based income) means the income methodology used for determining medical assistance eligibility for children through age eighteen, parents, caretaker relatives, pregnant women, and adults age nineteen through sixty-four.

(50) "Non-applicant" means a person who is not seeking an eligibility determination for himself or herself but is included in an applicant's medicaid household to determine eligibility for such applicant.

(51) "Non-cooperation" or "failure to cooperate" means failure by an individual to present required verifications, or to explain why it is not possible to present the verifications, after being notified the verification was required for eligibility determination.

(52) "Ohio works first (OWF) sanction" means that a member of an OWF assistance group has become ineligible for OWF payments for at least six months, as a result of his or her own failure to comply in full with a provision of a self-sufficiency contract related to work activities. A third or subsequent failure or refusal, without good cause, to comply with the self-sufficiency contract will also result in the loss of medical assistance eligibility.

(53) "Outstationing" means the federal requirement that administrative agencies provide opportunities for low-income pregnant women and children to apply for medical assistance at locations other than the local county department of job and family services.

(54) "Parent" means a natural, adoptive, or step-parent.

(55) "Personal property" means any property that is not real property. The term includes, but is not limited to, such things as cash, jewelry, household goods, tools, life insurance policies, automobiles, and promissory notes.

(56) "Post eligibility treatment of income" (PETI) means the process of calculating the patient liability, based on the amount of income remaining after allowable deductions, for an institutionalized individual.

(57) "Postpartum period" means a span of at least sixty days, beginning on the date a woman's pregnancy ends and ending on the last day of the month in which the sixtieth day falls.

(58) "Pre-termination review" (PTR) means a review of eligibility criteria completed prior to any termination of medical assistance, to determine whether an individual is eligible for any other category of medical assistance.

(59) "Private child placing agency" (PCPA) means any association that is certified to accept temporary, permanent, or legal custody of children and place the children for foster care or adoption, as defined in rule 5101:2-1-01 of the Administrative Code.

(60) "Program of all-inclusive care for the elderly" (PACE) means a program for individuals age fifty-five or older that provides an alternative to nursing home placement and a package of comprehensive services managed by a team of health professionals.

(a) Individuals found eligible for PACE under a base eligibility category as defined in paragraph (B)(7) of this rule, are not considered institutionalized and are not subject to post eligibility treatment of income (PETI) as defined in paragraph (B)(56) of this rule.

(b) Individuals found eligible for PACE using special income level (SIL) budgeting as defined in paragraph (B)(74) of this rule, are considered institutionalized and are subject to PETI.

(61) "Protected health information" (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium.

(62) "Public children services agency" (PCSA) means an entity that has assumed the powers and duties of the children services function for a county, as defined in rule 5101:2-1-01 of the Administrative Code.

(63) "Public institution" means an institution which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, as evidenced by final administrative control, including ownership and

control of the physical facilities and grounds.

(64) "Qualified entity" means the source of eligibility determinations for the presumptive eligibility program and is limited to the following:

(a) A county department of job and family services (CDJFS); or

(b) A hospital, the department of youth services (DYS), a federally qualified health center (FQHC) or a FQHC look-alike, that meet the requirements described in Chapter 5160-28 of the Administrative Code; or

(c) A local health department, a women, infants, and children (WIC) clinic, or other entity as designated by the director.

(65) "Real property" means land, including buildings or immovable objects, attached permanently to the land.

(66) "Refugee" means a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and is admitted to the United States under Section 207 of the Immigration and Nationality Act (INA), 8 U.S.C. 1157 (as in effect August 1, 2016).

(67) "Renew" or "renewal" means a review to determine whether the individual continues to meet all of the eligibility requirements of the medical assistance category. A renewal is performed annually or when information about possible changes to an individual's eligibility is received by the administrative agency.

(68) "Reporting" means notifying the administrative agency of any changes that may affect an individual's eligibility for medical assistance. Reporting changes and providing verifications is the responsibility of any individual, person, or entity who has a legal or financial responsibility for or who stands in the place of an individual, including:

(a) The individual;

(b) The individual's spouse, including a community spouse;

(c) The individual's parent, legal custodian, legal guardian, or caretaker relative; and

(d) The individual's authorized representative.

(69) "Residence" means the place the individual considers his or her established or principal home and to which, if absent, he or she intends to return.

(70) "Residential care facility" (RCF) means a home that provides accommodations described in section 3721.01 of the Revised Code.

(71) "Resources" means cash, funds held within a financial institution, investments, personal property, and real property an individual and/or the individual's spouse has an ownership interest in, has the legal ability to access in order to convert to cash (if not already cash), and is not legally prohibited from using for support and maintenance.

(72) "Safeguarding" means security measures taken to ensure that the information of individuals applying for or receiving medical assistance is protected against unauthorized inspection, disclosure, or use. Safeguarding also refers to the restriction on the use of, or disclosure of, individual information including federal tax information and returns (FTI), any protected health information (PHI), or other confidential information used in the administration of the medicaid program.

(73) "Self-declaration" means a statement or statements made by an individual.

(74) "Special income level" (SIL) means three hundred per cent of the current supplemental security income (SSI) payment standard. The SSI payment standard is also referred to as the federal benefit rate (FBR). SIL is used when an individual needs long-term care (LTC) services and has income over the allowable limits for base eligibility as defined in paragraph (B)(7) of this rule. Under SIL, an individual receives all services that are provided under a base eligibility category in addition to long-term care services as defined in paragraph (B)(42) of this rule.

(75) "Spouse" means a person who is legally married to another under Ohio law.

(76) "State adoption assistance" means the state-only adoption subsidy program as described in rule 5101:2-44-03 of the Administrative Code.

(77) "Support Services" means non-medical services offered or provided by the administrative agency to assist the individual and may include arranging or providing transportation, making medical appointments, accompanying the individual to medical appointments, and making referrals to community and other social services to be coordinated with the individual's medicaid-contracting managed care plan (MCP), where applicable.

(78) "Suspend" or "suspended" means the temporary termination or discontinuance of eligibility.

(79) "Temporary absence" means that an individual, who is otherwise considered part of the family, is considered not to have changed residence and intends to return.

(a) An individual is considered to be temporarily absent with no time limit when all of the following conditions are met:

(i) The location of the absent individual is known;

(ii) There is a definite plan for the return of the absent individual to the family's place of residence; and

(iii) The absent individual shared the place of residence with the family immediately prior to the absence, except for individuals described in paragraph (C)(1)(h) of rule 5160:1-4-02 of the Administrative Code.

(b) Child(ren) removed by the PCSA are considered temporarily absent as long as the reunification requirements specified in the reunification plan are met.

(c) Individuals who are confined, as described in rule 5160:1-1-03 of the Administrative Code, are not temporarily absent.

(80) "Terminate" or "terminated" means a determination by the administrative agency that an individual is no longer eligible, or has failed to cooperate with verification of eligibility, for one or more categories of assistance currently being received by that individual, resulting in a written notice of the administrative agency's intention to discontinue coverage under that category and providing notice of hearing rights as required by 42 C.F.R. 435.919 (as in effect August 1, 2016).

(81) "United States (U.S.)" and "state(s)" mean all fifty U.S. states, the District of Columbia, and the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, Swain's Island and the U.S. Virgin Islands.

(82) "United States citizen or national" means any individual who is:

(a) A citizen or national through birth or collective naturalization as set forth in 8 U.S.C. Chapter 12, Subchapter Ill, Part I (as in effect August 1, 2016); or

(b) A naturalized citizen or national as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part II (as in effect August 1, 2016).

(83) "Verification" means a document, statement, or other confirmation of information provided by an individual or by a third party to confirm statements made by the individual about any requirement for eligibility for medical assistance. A verification document or written statement may be an original, photocopy, facsimile (fax), or electronic version of the original,

unless otherwise stated.

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